

INPATIENT JUVENILE SERVICES INVOICE

Facility _____

Month

Year

	Name of Service Recipient	Social Security Number	Admission Date	Discharge Date	Length of Stay (# of days)	Amount Billed	Amount Approved for Payment by TDMHDD (For TDMHDD use only)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
TOTAL THIS PAGE							

Inpatient Forensic Coordinator/Financial or Reimbursement Representative

Date

TDMHDD Forensic Services Approval

Date